STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155506	A. BUILDING _____ B. WING _____	03/15/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANCTUARY AT HOLY CROSS--INDIANA	17475 DUGDALE DR SOUTH BEND, IN46635

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for investigation of complaint IN00087550. Complaint IN00087550 substantiated, Federal/State deficiencies related to the allegations are cited at F-224 , F-241, F-309, F 312, and F-469. Survey dates: March 14 and 15, 2011 Facility number: 001201 Provider number: 155506 Aim number: 100380860 Surveyors: Antoinette Krakowski, RN, TC Becky Luft, RN Vicki Manuwal, RN Census bed type: SNF/NF: 113 Total: 113 Census payor type: Medicare: 43 Medicaid: 56 Other: 14 Total: 113 Sample: 5 Supplemental Sample: 2 These deficiencies also reflect state	F0000	Submission and implementation of this plan of corection in no way constitutes an admission or agreement of the truth of facts alledged in this statement of deficiencies and plan of correction. In fact, this plan of correction is submitted and implemented soley to comply with State and Federal law.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155506	A. BUILDING _____ B. WING _____	03/15/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANCTUARY AT HOLY CROSS--INDIANA	17475 DUGDALE DR SOUTH BEND, IN46635

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	findings in accordance with 410 IAC 16.2. Quality review completed 3-20-11 Cathy Emswiller RN			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155506	A. BUILDING _____ B. WING _____	03/15/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANCTUARY AT HOLY CROSS--INDIANA	17475 DUGDALE DR SOUTH BEND, IN46635

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0224 SS=E	Based on observation, interview, and record review, the facility failed to ensure residents needs were met by answering call lights in a timely manner (Residents: #E and #F) and providing continence care to incontinent residents who were made to lie soiled in their bed (Residents #E, #G, #H) which resulted in the development of an open area for one resident (Resident # E). This deficient practice affected 2 of 5 residents (Residents: #E and #F) in the sample of 5 and 2 of 2 residents (Residents #G and #H) in the supplemental sample of 2 reviewed for incontinence. Findings include: 1. Resident # E's clinical record was reviewed on 3/15/11 at 3:00 P.M. and indicated diagnoses of, but not limited to: lung cancer, DVT (deep vein thrombosis) and pulmonary emboli. During an interview with alert and	F0224	F2241. What corrective action will be accomplished for those residents found to be affected by the deficient practice: Head to toe assessment were completed on all resident to ensure skin integrity. Medline representatives and nursing administration reviewed incontinence needs for incontinent residents and implemented new system and incontinence supplies to manage incontinent residents.2. How will other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken for any other affected resident:Rersidents requiring assistance with incontinence care have the potential to be affected.Medline representatives and nursing administration reviewed incontinence needs for incontinent residents and implemented new system and incontinence supplies to manage incontinent residents.Head to toe assessments were completed on incontinent residents to assure skin integrity.3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.All staff was inserviced on the expectation and responsibilities of answering call lights.Abuse and neglect training was provided to all staff.Nurse Administration has been assigned	03/29/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155506	A. BUILDING _____ B. WING _____	03/15/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANCTUARY AT HOLY CROSS--INDIANA	17475 DUGDALE DR SOUTH BEND, IN46635

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	oriented Resident # E on 3/15/11 at 2:40 P.M., she indicated she often has to wait two or more hours before someone comes to answer her call light. "If a person died in this place, no one would know until morning. What if my roommate had a heart attack? How would I get her help?" She further indicated she had been given a laxative because she was having difficulty with constipation and had soiled herself. "I had Depend's (an incontinence brief) on. I try to keep a Depend's on because you never know when they (staff) are going to show up. (CNA # 2) came in and told me she would clean me up when I finished. I didn't know if I was finished or not. I know it was loaded. She made me wait a long time before she came back to clean me up. The next day my butt was sore and bleeding. I am (age) years old and s--- and p----- my pants two times in one night because no one came." Resident # E indicated she had complained to Social Worker #8		off hour shifts to assure call lights and incontinence care of residents is timely.4. How the corrective action will be monitored to ensure the deficient practice will not recur.Nursing administration will audit all units for compliance with answering call lights and incontinence care is being provided timely,one time per shift on all 3 shifts and total of four times per week report findings to the Director of Nursing at morning clinical meeting.Social worker will randomly question 2 staff per day 5 days a week to ensure staffs lnowledge of abuse and neglect responsibilities and report findings to the administrator daily at clinical meetings.Social Worker will interview 5% of residents and /or families weekly to ensure quality of care is being provided to residents.Corporate Regional Nurse will round community daily 3 days per week for 6 months to ensure call lights are answered and incontinence care is provided timely.Director of Nursing and Administrator will review, follow up and report audit findings to (MDQI) monthly until 100% compliance is obtained times 3 months.5. Completion date March 29, 2011	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155506	A. BUILDING _____ B. WING _____	03/15/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANCTUARY AT HOLY CROSS--INDIANA	17475 DUGDALE DR SOUTH BEND, IN46635

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	about her concerns. A Social Service MDS (Minimum Data Set) Assessment Note, dated 3/15/11, indicated, "...Resident (#E) is alert and oriented to time, place, and situation. Resident scored 15 out of 15 indicating normal cognitive functioning on 3/07/11...." Nurse's Notes, dated 3/09/11 at 2 P.M., indicated, "...tub bath given. Skin check revealed 2 areas of excoriation bilat (bilaterally) inner buttocks L (left) inner buttocks measures 0.5 x 1.0 (centimeters) pink tissue & R (right) inner buttocks measures 1.0 x 1.5 (centimeters) pink tissue superficial depth...." An "Admission Resident Data Set Assessment," undated, indicated she did not have the above mentioned areas upon admission on 3/04/11.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155506	A. BUILDING _____ B. WING _____	03/15/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANCTUARY AT HOLY CROSS--INDIANA	17475 DUGDALE DR SOUTH BEND, IN46635

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Review of the Grievance Log indicated Resident #E complained to administration on two separate occasions regarding call light response times and staffing concerns. Social Worker # 8 indicated in an interview on 3/15/11 at 5:45 P.M. that it was not reported to her that a CNA left the resident soiled. I met with the resident, but her complaint was that she couldn't get herself up to the bathroom because of weakness and safety issues. I immediately went to the therapy department and they began working with her. She never mentioned the other issue. During observation of Resident # E's skin on 3/15/11 at 5:05 P.M., while accompanied by Unit Manager # 6, Resident E's open areas appeared to be healed. Resident # E indicated at the time of the observation that the areas no longer caused her pain.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155506	A. BUILDING _____ B. WING _____	03/15/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANCTUARY AT HOLY CROSS--INDIANA	17475 DUGDALE DR SOUTH BEND, IN46635

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	2. During initial tour of the facility on 3/14/11 at 11:10 P.M., while accompanied by LPN # 5, Resident #G was observed lying asleep in his bed. LPN # 5 identified Resident #G as incontinent and in need of two hour checks for incontinence. Upon further observation, Resident #G was found to be soiled from urine. His quilted incontinence pad had a small wet area surrounded by a larger, dry, golden brown stain of dried urine. Review of Resident #G's clinical record on 3/15/11 at 5:35 P.M., indicated diagnoses of, but not limited to: Alzheimer's dementia, depression, and history of urinary tract infection. Resident #G's most recent quarterly MDS (Minimum Data Set) assessment, dated 2/11/11, indicated his cognition was severely impaired and he never or rarely made decisions. It further			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155506	A. BUILDING _____ B. WING _____	03/15/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANCTUARY AT HOLY CROSS--INDIANA	17475 DUGDALE DR SOUTH BEND, IN46635

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	indicated he needed extensive assistance of two persons with physical assist for toileting. A Care Plan, dated 1/11/11, indicated, "Problem: I have altered urinary elimination pattern related to dx. (diagnosis) of dementia...Approach: ...Keep me dry and clean after each incontinence episode...." A Nurse's Note, dated 3/15/11 at 12:00 P.M., indicated, "...Resident continues on antibiotic dx. (diagnosis) UTI (urinary tract infection)...resident remains incontinent of bowel & bladder...." 3. During initial tour of the facility on 3/14/11 at 11:45 P.M., while accompanied by LPN # 7, Resident #H was observed lying in her bed. Her call light control was observed lying on the floor at the right side of her bed. LPN # 7 pulled back the blankets and checked Resident #H to determine if she had been			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155506	A. BUILDING _____ B. WING _____	03/15/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANCTUARY AT HOLY CROSS--INDIANA	17475 DUGDALE DR SOUTH BEND, IN46635

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	incontinent. A white terry towel was observed lying beneath the top sheet and on top of Resident H's groin area. There was a strong urine odor present. When LPN #7 repositioned the resident, a large, dry, golden brown area was observed beneath Resident #H. The outer ring of the area was a darker brown than the center. LPN #7 indicated the area was dry. Resident H's clinical record was reviewed on 3/15/11 at 6:10 P.M. and indicated diagnoses of, but not limited to: dehydration, dyspnea (shortness of breath) on exertion, and failure to thrive. A Nurse's Note, dated 3/10/11 at 10:30 P.M., indicated, "...Able to use call light et (and) voice needs...Extensive assist for personal care-toileting, personal hygiene, dressing, ADL's (activities of daily living)...." During interview with LPN #7 at			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155506	A. BUILDING _____ B. WING _____	03/15/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANCTUARY AT HOLY CROSS--INDIANA	17475 DUGDALE DR SOUTH BEND, IN46635

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	the time of the observation, she indicated the evening shift makes sure all the residents are clean and repositioned prior to leaving their shift at 11:15 P.M. and the night shift begins resident checks immediately after receiving report. 4. During initial tour of the facility on 3/14/11 at 11:50 P.M., Resident #F's family member reported the poor response of facility staff to answering call lights and providing necessary care. She indicated she has found her mother with dried feces on her backside and between her legs. "I frequently find her with an odor and her call light disabled." She indicated she saw the call light on across the hall from her mother and witnessed a CNA enter the room and immediately exit. The call light had been turned off. After some time, the resident began calling out and Resident #F's daughter went into the room to check on the resident. She informed the resident to put her call light			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155506	A. BUILDING _____ B. WING _____	03/15/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANCTUARY AT HOLY CROSS--INDIANA	17475 DUGDALE DR SOUTH BEND, IN46635

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	back on and was told by the resident that she had tried, but it stopped working. "I know someone did something because I've found my mother's call light like that. We have waited two hours with the call light on during the evening shift. There's nothing you can do about it because there isn't anyone around. The nurse's won't answer the lights, they pass the medications and sit at the desk. I'm willing to organize a fund raiser so the facility can afford to hire some part-time help. I hear people calling out 'Help me. Help me." Resident #F's clinical record was reviewed on 3/15/11 at 4:35 P.M. and indicated diagnoses of, but not limited to: history of CVA (stroke), diabetes, and vascular dementia. Review of Resident #F's MDS (Minimum Data Set) Assessment, dated 1/21/11, indicated, she needed extensive physical assistance of two staff for toilet use			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155506	A. BUILDING _____ B. WING _____	03/15/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANCTUARY AT HOLY CROSS--INDIANA	17475 DUGDALE DR SOUTH BEND, IN46635

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	(how resident uses the toilet room, commode, bedpan, or urinal; transfers on/off toilet; cleanses self after elimination). It further indicated Resident #F was frequently incontinent of urine and occasionally incontinent of bowel. A Care Plan, updated 1/20/11, indicated, "Problem(s): I require extensive assist with ADL's (activities of daily living) due to weakness, decreased mobility and effects of CVA...Approach(s): ...Encourage me to use call light for assistance. Remind me where it is when you're ready to leave the room...I need assist with proper pericare after each incontininт (sic) episode...." A Social Service Progress Note, dated 1/24/11 at 3:42 P.M., indicated, "...Res (resident) is alert and oriented to person with forgetfulness...Severe cognitive impairment...."			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155506	A. BUILDING _____ B. WING _____	03/15/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANCTUARY AT HOLY CROSS--INDIANA	17475 DUGDALE DR SOUTH BEND, IN46635

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	During an interview with a second family member on 3/15/11 at 4:20 P.M., she indicated it takes a long time for staff to answer call lights. She further indicated she found her mother in BM (bowel movement) three weeks ago. A facility policy titled "Incontinence Management, Urinary," dated 1/08/11, indicated, "...To manage functional (total) incontinence, frequently assess the patient's mental and functional status...respond to his calls promptly...clean the perineal area frequently...control foul odors as well...." A facility policy titled, Incontinence Management, Fecal," dated 1/08/11, indicated, "...In elderly patients, fecal incontinence commonly follows any loss or impairment of anal sphincter control...maintain effective hygienic care to increase the patient's comfort and prevent skin breakdown and infection.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155506	A. BUILDING _____ B. WING _____	03/15/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANCTUARY AT HOLY CROSS--INDIANA	17475 DUGDALE DR SOUTH BEND, IN46635

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Clean the perineal area frequently with a skin cleaner, and apply a skin protectant cream after every incontinence episode. Control foul odors as well...." This federal tag relates to Complaints IN00087550. 3.1-27(a)(3)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155506	A. BUILDING _____ B. WING _____	03/15/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANCTUARY AT HOLY CROSS--INDIANA	17475 DUGDALE DR SOUTH BEND, IN46635

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0241 SS=E	Based on observation, interview, and record review, the facility failed to respect the dignity of 4 residents as evidenced by observation of 2 soiled residents (Residents: #G, #H), an interview with 1 alert and oriented resident (Resident #E) and interviews with family members of an incontinent resident (Resident #F) left soiled, and 1 resident (Resident #C) with a folded bed pad between her legs. This deficient practice affected 3 of 5 residents in the sample of 5 and 2 of 2 residents in the supplemental sample reviewed for continence care. Findings include: 1. During initial tour of the facility on 3/14/11 at 11:10 P.M., while accompanied by LPN # 5, Resident #G was observed lying asleep in his bed. LPN # 5 identified Resident #G as incontinent and in need of two hour checks for incontinence. Upon further observation, Resident	F0241	1. What corrective action will be accomplished for those residents found to be affected by the deficient practice: Head to toe skin assessments were completed on all resident to ensure skin integrity. Medline representatives and nursing administration reviewed incontinence needs for incontinent residents and implemented new system and incontinence supplies to manage incontinent residents.2. How will other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken for any other affected residents.Residents requiring assistance with toileting needs have the potential to be affected.Medline representatives and nursing administration reviewed incontinence needs for incontinent residents and implemented new system and incontinence supplies to manage incontinent residents.Head to toe skin assessments were completed on incontinent residents to assure skin integrity.Nurse administration has been assigned on off hour shifts to assure call lights and care of residents is timely including answering call lights, incontinence care and dignity is provided.3. What measures will be put into place or what systemic changes will be made to ensure	03/29/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155506	A. BUILDING _____ B. WING _____	03/15/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANCTUARY AT HOLY CROSS--INDIANA	17475 DUGDALE DR SOUTH BEND, IN46635

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	#G was found to be soiled from urine. His quilted incontinence pad had a small wet area surrounded by a larger, dry, golden brown stain of dried urine. Review of Resident #G's clinical record on 3/15/11 at 5:35 P.M., indicated diagnoses of, but not limited to: Alzheimer's dementia, depression, and history of urinary tract infection. Resident #G's most recent quarterly MDS (Minimum Data Set) assessment, dated 2/11/11, indicated his cognition was severely impaired and he never or rarely made decisions. It further indicated he needed extensive assistance of two persons with physical assist for toileting. A Care Plan, dated 1/11/11, indicated, "Problem: I have altered urinary elimination pattern related to dx. (diagnosis) of dementia...Approach: ...Keep me		that the deficient practice does not recur.All staff was inserviced on the expectation and responsibilities of answering call lights.Dignity training was provided to all staff.4. How the corrective action will be monitored to ensure the deficient practice will not recur.Nursing administration will audit all units for compliance with answering call lights and incontinence care is provided timely,one time per shift on all 3 shifts and a total of four times per week report findings to the Director of Nursing at morning clinical meeting.Social worker will randomly question 2 staff per day 5 days a week to ensure staffs lnowledge of abuse and neglect responsibilities and report findings to the administrator daily at clinical meetings.Social Worker will interview 5% of residents and /or families weekly to ensure quality of care is being provided to residents.Corporate Regional Nurse will round community daily 3 days per week for 6 months to ensure call lights are answered and incontinence care is provided timely.Director of Nursing and Administrator will review, follow up and report audit findings to (MDQI) monthly until 100% compliance is obtained times 3 months.5. Completion date March 29, 2011	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155506	A. BUILDING _____ B. WING _____	03/15/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANCTUARY AT HOLY CROSS--INDIANA	17475 DUGDALE DR SOUTH BEND, IN46635

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	dry and clean after each incontinence episode...." A Nurse's Note, dated 3/15/11 at 12:00 P.M., indicated, "...Resident continues on antibiotic dx. (diagnosis) UTI (urinary tract infection)...resident remains incontinent of bowel & bladder...." 2. During initial tour of the facility on 3/14/11 at 11:45 P.M., while accompanied by LPN # 7, Resident #H was observed lying in her bed. Her call light control was observed lying on the floor at the right side of her bed. LPN # 7 pulled back the blankets and checked Resident #H to determine if she had been incontinent. A white terry towel was observed lying beneath the top sheet and on top of Resident H's groin area. There was a strong urine odor present. When LPN #7 repositioned the resident, a large, dry, golden brown area was observed beneath Resident #H. The outer ring of the area was a darker			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155506	A. BUILDING _____ B. WING _____	03/15/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANCTUARY AT HOLY CROSS--INDIANA	17475 DUGDALE DR SOUTH BEND, IN46635

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	brown than the center. LPN #7 indicated the area was dry. Resident H's clinical record was reviewed on 3/15/11 at 6:10 P.M. and indicated diagnoses of, but not limited to: dehydration, dyspnea (shortness of breath) on exertion, and failure to thrive. A Nurse's Note, dated 3/10/11 at 10:30 P.M., indicated, "...Able to use call light et (and) voice needs...Extensive assist for personal care-toileting, personal hygiene, dressing, ADL's (activities of daily living)...." During interview with LPN #7 at the time of the observation, she indicated the evening shift makes sure all the residents are clean and repositioned prior to leaving their shift at 11:15 P.M. and the night shift begins resident checks immediately after receiving report. 3. Resident # E's clinical record			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155506	A. BUILDING _____ B. WING _____	03/15/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANCTUARY AT HOLY CROSS--INDIANA	17475 DUGDALE DR SOUTH BEND, IN46635

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	was reviewed on 3/15/11 at 3:00 P.M. and indicated diagnoses of, but not limited to: lung cancer, DVT (deep vein thrombosis) and pulmonary emboli. During an interview with alert and oriented Resident # E on 3/15/11 at 2:40 P.M., she indicated she often has to wait two or more hours before someone comes to answer her call light. "If a person died in this place, no one would know until morning. What if my roommate had a heart attack? How would I get her help?" She further indicated she had been given a laxative because she was having difficulty with constipation and had soiled herself. "I had Depend's (an incontinence brief) on. I try to keep a Depend's on because you never know when they (staff) are going to show up. (CNA # 2) came in and told me she would clean me up when I finished. I didn't know if I was finished or not. I know it was loaded. She made me wait a long time before			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155506	A. BUILDING _____ B. WING _____	03/15/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANCTUARY AT HOLY CROSS--INDIANA	17475 DUGDALE DR SOUTH BEND, IN46635

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	she came back to clean me up. The next day my butt was sore and bleeding. I am (age) years old and s--- and p----- my pants two times in one night because no one came." Resident # E indicated she had complained to Social Worker #8 about her concerns. A Social Service MDS (Minimum Data Set) Assessment Note, dated 3/15/11, indicated, "...Resident (#E) is alert and oriented to time, place, and situation. Resident scored 15 out of 15 indicating normal cognitive functioning on 3/07/11...." 4. During initial tour of the facility on 3/14/11 at 11:50 P.M., Resident #F's family member reported the poor response of facility staff to answering call lights and providing necessary care. She indicated she has found her mother with dried feces on her backside and between her legs. "I frequently find her with an odor and her call light disabled."			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155506	A. BUILDING _____ B. WING _____	03/15/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANCTUARY AT HOLY CROSS--INDIANA	17475 DUGDALE DR SOUTH BEND, IN46635

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	She indicated she saw the call light on across the hall from her mother and witnessed a CNA enter the room and immediately exit. The call light had been turned off. After some time, the resident began calling out and Resident #F's daughter went into the room to check on the resident. She informed the resident to put her call light back on and was told by the resident that she had tried, but it stopped working. "I know someone did something because I've found my mother's call light like that. We have waited two hours with the call light on during the evening shift. There's nothing you can do about it because there isn't anyone around. The nurse's won't answer the lights, they pass the medications and sit at the desk. I'm willing to organize a fund raiser so the facility can afford to hire some part-time help. I hear people calling out 'Help me. Help me." Resident #F's clinical record was			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155506	A. BUILDING _____ B. WING _____	03/15/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANCTUARY AT HOLY CROSS--INDIANA	17475 DUGDALE DR SOUTH BEND, IN46635

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	reviewed on 3/15/11 at 4:35 P.M. and indicated diagnoses of, but not limited to: history of CVA (stroke), diabetes, and vascular dementia. Review of Resident #F's MDS (Minimum Data Set) Assessment, dated 1/21/11, indicated, she needed extensive physical assistance of two staff for toilet use (how resident uses the toilet room, commode, bedpan, or urinal; transfers on/off toilet; cleanses self after elimination). It further indicated Resident #F was frequently incontinent of urine and occasionally incontinent of bowel. A Care Plan, updated 1/20/11, indicated, "Problem(s): I require extensive assist with ADL's (activities of daily living) due to weakness, decreased mobility and effects of CVA...Approach(s): ...Encourage me to use call light for assistance. Remind me where it is when you're ready to leave the room...I need assist with proper			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155506	A. BUILDING _____ B. WING _____	03/15/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANCTUARY AT HOLY CROSS--INDIANA	17475 DUGDALE DR SOUTH BEND, IN46635

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	pericare after each incontinint (sic) episode...." A Social Service Progress Note, dated 1/24/11 at 3:42 P.M., indicated, "...Res (resident) is alert and oriented to person with forgetfulness...Severe cognitive impairment...." During an interview with a second family member on 3/15/11 at 4:20 P.M., she indicated it takes a long time for staff to answer call lights. She further indicated she found her mother in BM (bowel movement) three weeks ago. A facility policy titled "Incontinence Management, Urinary," dated 1/08/11, indicated, "...To manage functional (total) incontinence, frequently assess the patient's mental and functional status...respond to his calls promptly...clean the perineal area frequently...control foul odors as well...."			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155506	A. BUILDING _____ B. WING _____	03/15/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANCTUARY AT HOLY CROSS--INDIANA	17475 DUGDALE DR SOUTH BEND, IN46635

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	A facility policy titled, Incontinence Management, Fecal," dated 1/08/11, indicated, "...In elderly patients, fecal incontinence commonly follows any loss or impairment of anal sphincter control...maintain effective hygienic care to increase the patient's comfort and prevent skin breakdown and infection. Clean the perineal area frequently with a skin cleaner, and apply a skin protectant cream after every incontinence episode. Control foul odors as well...."			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155506	A. BUILDING _____ B. WING _____	03/15/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANCTUARY AT HOLY CROSS--INDIANA	17475 DUGDALE DR SOUTH BEND, IN46635

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0241 SS=E	5. The clinical record for Resident # C, reviewed on 3/15/11 at 2:55 P.M., indicated diagnoses of, but not limited to: hypertension, CVA (cerebrovascular accident/stroke) with right hemiparesis (weakness), and expressive aphasia (loss of the ability to produce language). During initial tour of the facility conducted on 3/14/11 at 10:55 P.M., with LPN # 5, Resident # C was found asleep in her bed with two, approximately two feet by three feet, dry, quilted, incontinent pads underneath her bottom along with a dry, folded in quarters, approximately three inches thick, quilted, incontinent pad between her legs extending from the small of her back up to her naval. LPN # 5 removed the pad between the Resident's legs. LPN # 5 indicated she would find out who the CNA was that placed the pad between her legs. Review of the "MDS (Minimum	F0241	1. What corrective action will be accomplished for those residents found to be affected by the deficient practice: Head to toe skin assessments were completed on all resident to ensure skin integrity. Medline representatives and nursing administration reviewed incontinence needs for incontinent residents and implemented new system and incontinence supplies to manage incontinent residents.2. How will other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken for any other affected residents.Residents requiring assistance with toileting needs have the potential to be affected.Medline representatives and nursing administration reviewed incontinence needs for incontinent residents and implemented new system and incontinence supplies to manage incontinent residents.Head to toe skin assessments were completed on incontinent residents to assure skin integrity.Nurse administration has been assigned on off hour shifts to assure call lights and care of residents is timely including answering call lights, incontinence care and dignity is provided.3. What measures will be put into place or what systemic changes will be made to ensure	03/29/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155506	A. BUILDING _____ B. WING _____	03/15/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANCTUARY AT HOLY CROSS--INDIANA	17475 DUGDALE DR SOUTH BEND, IN46635

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Data Set)...Nursing Home Discharge Assessment...", dated 2/4/11, indicated "...Cognitive skills for daily decision making...moderately impaired-decisions poor; cues/supervision required...ADL (activities of daily living) self-performance...Toilet use...Extensive assistance...one person physical assist...Urinary continence...Frequently incontinent...." A facility care plan for Resident # C, dated 3/10/11, indicated, "...Problem(s)...I am incontinent of both bowel and bladder...Keep me dry and clean after each incontinence episode...Respond to my call light promptly...." This federal tag relates to Complaints IN00087550. 3.1-3(t)		that the deficient practice does not recur.All staff was inserviced on the expectation and responsibilities of answering call lights.Dignity training was provided to all staff.4. How the corrective action will be monitored to ensure the deficient practice will not recur.Nursing administration will audit all units for compliance with answering call lights and incontinence care is provided timely,one time per shift on all 3 shifts and a total of four times per week report findings to the Director of Nursing at morning clinical meeting.Social worker will randomly question 2 staff per day 5 days a week to ensure staffs lnowledge of abuse and neglect responsibilities and report findings to the administrator daily at clinical meetings.Social Worker will interview 5% of residents and /or families weekly to ensure quality of care is being provided to residents.Corporate Regional Nurse will round community daily 3 days per week for 6 months to ensure call lights are answered and incontinence care is provided timely.Director of Nursing and Administrator will review, follow up and report audit findings to (MDQI) monthly until 100% compliance is obtained times 3 months.5. Completion date March 29, 2011	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155506	A. BUILDING _____ B. WING _____	03/15/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANCTUARY AT HOLY CROSS--INDIANA	17475 DUGDALE DR SOUTH BEND, IN46635

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155506	A. BUILDING _____ B. WING _____	03/15/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANCTUARY AT HOLY CROSS--INDIANA	17475 DUGDALE DR SOUTH BEND, IN46635

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0309 SS=D	Based on observation, interview, and record review, the facility failed to respond to call lights and provide care in a timely manner for 2 of 5 residents in the sample of 5 (Residents: #E and #F) and 1 of 2 residents in the supplemental sample of 2 (Resident #H) reviewed for care and services. Findings include: 1. Resident # E's clinical record was reviewed on 3/15/11 at 3:00 P.M. and indicated diagnoses of, but not limited to: lung cancer, DVT (deep vein thrombosis) and pulmonary emboli. During an interview with alert and oriented Resident # E on 3/15/11 at 2:40 P.M., she indicated she often has to wait two or more hours before someone comes to answer her call light. "If a person died in this place, no one would know until morning. What if my roommate had a heart attack? How would I get her	F0309	1. What corrective action will be accomplished for those residents found to be affected by the deficient practice: Head to toe skin assessment were completed on all resident to ensure skin integrity. Medline representatives and nursing administration reviewed incontinence needs for incontinent residents and implemented new system and incontinence supplies to manage incontinent residents. 2. How will other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken for any other affected resident:Resident requiring assistance with toileting needs have the potential to be affected.Medline representatives and nursing administration reviewed incontinence needs for incontinent residents and implemented new system and incontinence supplies to manage incontinent residents.Head to toe skin assessments were completed on incontinent residents to assure skin integrity.Nursing administration has been assigned on off-hour shifts to assure call lights and care of residents is timely.3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.All staff inserviced on the	03/29/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155506	A. BUILDING _____ B. WING _____	03/15/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANCTUARY AT HOLY CROSS--INDIANA	17475 DUGDALE DR SOUTH BEND, IN46635

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	help?" She further indicated she had been given a laxative because she was having difficulty with constipation and had soiled herself. "I had Depend's (an incontinence brief) on. I try to keep a Depend's on because you never know when they (staff) are going to show up. (CNA # 2) came in and told me she would clean me up when I finished. I didn't know if I was finished or not. I know it was loaded. She made me wait a long time before she came back to clean me up. The next day my butt was sore and bleeding. I am (age) years old and s--- and p----- my pants two times in one night because no one came." Resident # E indicated she had complained to Social Worker #8 about her concerns. A Social Service MDS (Minimum Data Set) Assessment Note, dated 3/15/11, indicated, "...Resident (#E) is alert and oriented to time, place, and situation. Resident scored 15 out of 15 indicating normal		expectation and responsibilities of anwersing call lights timely,one time per shift on all 3 shifts and a total of four times per week report findings to the Director of Nursing at morning clinical meeting. Medline representatives and nursing administration provided education to direct care staff related to providing care for incontinent residents and implementation for the system and use of incontinent supplies.4. How will the corrective action be monitored to ensure the deficient practice will not recur.Nursing administration will audit all units for compliance with answering call lights and providing incontinence care timely, randomly on all 3 shifts and report findings to the Director of Nursing at morning clinical meeting.Corporate Regional Nurse will round community daily 3 days per week for 6 months to ensure call lights are answered and incontinence care is provided timely.Director of Nursing and Administrator will review, follow up and report audit findings to (MDQI) monthly until 100% compliance is obtained times 3 months.5. Completion date March 29,2011	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155506	A. BUILDING _____ B. WING _____	03/15/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANCTUARY AT HOLY CROSS--INDIANA	17475 DUGDALE DR SOUTH BEND, IN46635

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	cognitive functioning on 3/07/11...." Nurse's Notes, dated 3/09/11 at 2 P.M., indicated, "...tub bath given. Skin check revealed 2 areas of excoriation bilat (bilaterally) inner buttocks L (left) inner buttocks measures 0.5 x 1.0 (centimeters) pink tissue & R (right) inner buttocks measures 1.0 x 1.5 (centimeters) pink tissue superficial depth...." An "Admission Resident Data Set Assessment," undated, indicated she did not have the above mentioned areas upon admission on 3/04/11. During observation of Resident # E's skin on 3/15/11 at 5:05 P.M., while accompanied by Unit Manager # 6, Resident E's open areas appeared to be healed. Resident # E indicated at the time of the observation that the areas no longer caused her pain.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155506	A. BUILDING _____ B. WING _____	03/15/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANCTUARY AT HOLY CROSS--INDIANA	17475 DUGDALE DR SOUTH BEND, IN46635

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	2. During initial tour of the facility on 3/14/11 at 11:45 P.M., while accompanied by LPN # 7, Resident #H was observed lying in her bed. Her call light control was observed lying on the floor at the right side of her bed. LPN # 7 pulled back the blankets and checked Resident #H to determine if she had been incontinent. A white terry towel was observed lying beneath the top sheet and on top of Resident H's groin area. There was a strong urine odor present. When LPN #7 repositioned the resident, a large, dry, golden brown area was observed beneath Resident #H. The outer ring of the area was a darker brown than the center. LPN #7 indicated the area was dry. Resident H's clinical record was reviewed on 3/15/11 at 6:10 P.M. and indicated diagnoses of, but not limited to: dehydration, dyspnea (shortness of breath) on exertion, and failure to thrive.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155506	A. BUILDING _____ B. WING _____	03/15/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANCTUARY AT HOLY CROSS--INDIANA	17475 DUGDALE DR SOUTH BEND, IN46635

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

A Nurse's Note, dated 3/10/11 at 10:30 P.M., indicated, "...Able to use call light et (and) voice needs...Extensive assist for personal care-toileting, personal hygiene, dressing, ADL's (activities of daily living)...."

During interview with LPN #7 at the time of the observation, she indicated the evening shift makes sure all the residents are clean and repositioned prior to leaving their shift at 11:15 P.M. and the night shift begins resident checks immediately after receiving report.

3. During initial tour of the facility on 3/14/11 at 11:50 P.M., Resident #F's family member reported the poor response of facility staff to answering call lights and providing necessary care. "I frequently find her with an odor and her call light disabled." She indicated she saw the call light on across the hall from her mother and witnessed a CNA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155506	A. BUILDING _____ B. WING _____	03/15/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANCTUARY AT HOLY CROSS--INDIANA	17475 DUGDALE DR SOUTH BEND, IN46635

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	enter the room and immediately exit. The call light had been turned off. After some time, the resident began calling out and Resident #F's daughter went into the room to check on the resident. She informed the resident to put her call light back on and was told by the resident that she had tried, but it stopped working. "I know someone did something because I've found my mother's call light like that. We have waited two hours with the call light on during the evening shift. There's nothing you can do about it because there isn't anyone around. The nurse's won't answer the lights, they pass the medications and sit at the desk. I'm willing to organize a fund raiser so the facility can afford to hire some part-time help. I hear people calling out 'Help me. Help me." Resident #F's clinical record was reviewed on 3/15/11 at 4:35 P.M. and indicated diagnoses of, but not limited to: history of CVA (stroke),			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155506	A. BUILDING _____ B. WING _____	03/15/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANCTUARY AT HOLY CROSS--INDIANA	17475 DUGDALE DR SOUTH BEND, IN46635

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	diabetes, and vascular dementia. Review of Resident #F's MDS (Minimum Data Set) Assessment, dated 1/21/11, indicated, she needed extensive physical assistance of two staff for toilet use (how resident uses the toilet room, commode, bedpan, or urinal; transfers on/off toilet; cleanses self after elimination). It further indicated Resident #F was frequently incontinent of urine and occasionally incontinent of bowel. A Care Plan, updated 1/20/11, indicated, "Problem(s): I require extensive assist with ADL's (activities of daily living) due to weakness, decreased mobility and effects of CVA...Approach(s): ...Encourage me to use call light for assistance. Remind me where it is when you're ready to leave the room...." A Social Service Progress Note, dated 1/24/11 at 3:42 P.M.,			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155506	A. BUILDING _____ B. WING _____	03/15/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANCTUARY AT HOLY CROSS--INDIANA	17475 DUGDALE DR SOUTH BEND, IN46635

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	indicated, "...Res (resident) is alert and oriented to person with forgetfulness...Severe cognitive impairment...." During an interview with a second family member on 3/15/11 at 4:20 P.M., she indicated it takes a long time for staff to answer call lights. She further indicated she found her mother in BM (bowel movement) three weeks ago. A facility policy titled "Incontinence Management, Urinary," dated 1/08/11, indicated, "...To manage functional (total) incontinence, frequently assess the patient's mental and functional status...respond to his calls promptly...." A facility policy titled, Incontinence Management, Fecal," dated 1/08/11, indicated, "...In elderly patients, fecal incontinence commonly follows any loss or impairment of anal sphincter control...maintain			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155506	A. BUILDING _____ B. WING _____	03/15/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANCTUARY AT HOLY CROSS--INDIANA	17475 DUGDALE DR SOUTH BEND, IN46635

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	effective hygienic care to increase the patient's comfort and prevent skin breakdown and infection...." This federal tag relates to Complaints IN00087550. 3.1-37(a)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155506	A. BUILDING _____ B. WING _____	03/15/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANCTUARY AT HOLY CROSS--INDIANA	17475 DUGDALE DR SOUTH BEND, IN46635

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0312 SS=E	Based on observation, interview, and record review, the facility failed to provide continence care in a timely manner for 4 incontinent residents. This deficient practice affected 2 of 5 residents (Residents: #E and #F) in the sample of 5 and 2 of 2 residents (Residents #G and #H) in the supplemental sample of 2 reviewed for continence care. Findings include: 1. During initial tour of the facility on 3/14/11 at 11:10 P.M., while accompanied by LPN # 5, Resident #G was observed lying asleep in his bed. LPN # 5 identified Resident #G as incontinent and in need of two hour checks for incontinence. Upon further observation, Resident #G was found to be soiled from urine. His quilted incontinence pad had a small wet area surrounded by a larger, dry, golden brown stain of dried urine. Review of Resident #G's clinical	F0312	1. What corrective action will be accomplished for those residents found to be affected by the deficient practice:Head to toe assessment were completed on all resident to ensure skin integrity. Medline representatives and nursing administration reviewed incontinence needs for incontinent residents and implemented new system and incontenance supplies to manage incontinent residents.2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken for any other affected resident.Residents requiring assistance with toileting needs have the potential to be affected.Medline representatives and nursing administration reviewed incontinence needs for incontinent residents and implemented new system and incontenance supplies to manage incontinent residents.Head to toe assessments were completed on incontinent residents to assure skin integrity.Nurse administration has been assigned on all off-hour shifts to assure call lights and care of residents is timely.3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.All staff inserviced on the expectation and responsibilities of answering call lights	03/29/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155506	A. BUILDING _____ B. WING _____	03/15/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANCTUARY AT HOLY CROSS--INDIANA	17475 DUGDALE DR SOUTH BEND, IN46635

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	record on 3/15/11 at 5:35 P.M., indicated diagnoses of, but not limited to: Alzheimer's dementia, depression, and history of urinary tract infection. Resident #G's most recent quarterly MDS (Minimum Data Set) assessment, dated 2/11/11, indicated his cognition was severely impaired and he never or rarely made decisions. It further indicated he needed extensive assistance of two persons with physical assist for toileting. A Care Plan, dated 1/11/11, indicated, "Problem: I have altered urinary elimination pattern related to dx. (diagnosis) of dementia...Approach: ...Keep me dry and clean after each incontinence episode...." A Nurse's Note, dated 3/15/11 at 12:00 P.M., indicated, "...Resident continues on antibiotic dx. (diagnosis) UTI (urinary tract		timely.Medline representatives and nursing administration provided education to direct care staff related to providing care for incontinent residents and implementation for the system and use of incontinent supplies.4. How will the corrective action be monitored to ensure the deficient practice will not recure.Nursing administration will audit all units for compliance with answering call lights and providing incontinence care timely, one time per shift on all 3 shifts and total of four times per week report findings to the Director of Nursing at morning clinical meetings.Coroporate Regional Nurse will round community daily 3 days per week for 6 months to ensure call lights are answered and incontinence care is provided timely.Director of Nursing and Administrator will review, follow up and report audit findings to (MDQI) monthly until 100% compliance is obtained times 3 months.5. Completion date March 29, 2011	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155506	A. BUILDING _____ B. WING _____	03/15/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANCTUARY AT HOLY CROSS--INDIANA	17475 DUGDALE DR SOUTH BEND, IN46635

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	infection)...resident remains incontinent of bowel & bladder...." 2. During initial tour of the facility on 3/14/11 at 11:45 P.M., while accompanied by LPN # 7, Resident #H was observed lying in her bed. Her call light control was observed lying on the floor at the right side of her bed. LPN # 7 pulled back the blankets and checked Resident #H to determine if she had been incontinent. A white terry towel was observed lying beneath the top sheet and on top of Resident H's groin area. There was a strong urine odor present. When LPN #7 repositioned the resident, a large, dry, golden brown area was observed beneath Resident #H. The outer ring of the area was a darker brown than the center. LPN #7 indicated the area was dry. Resident H's clinical record was reviewed on 3/15/11 at 6:10 P.M. and indicated diagnoses of, but not limited to: dehydration, dyspnea			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155506	A. BUILDING _____ B. WING _____	03/15/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANCTUARY AT HOLY CROSS--INDIANA	17475 DUGDALE DR SOUTH BEND, IN46635

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	(shortness of breath) on exertion, and failure to thrive. A Nurse's Note, dated 3/10/11 at 10:30 P.M., indicated, "...Able to use call light et (and) voice needs...Extensive assist for personal care-toileting, personal hygiene, dressing, ADL's (activities of daily living)...." During interview with LPN #7 at the time of the observation, she indicated the evening shift makes sure all the residents are clean and repositioned prior to leaving their shift at 11:15 P.M. and the night shift begins resident checks immediately after receiving report. 3. Resident # E's clinical record was reviewed on 3/15/11 at 3:00 P.M. and indicated diagnoses of, but not limited to: lung cancer, DVT (deep vein thrombosis) and pulmonary emboli. During an interview with alert and			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155506	A. BUILDING _____ B. WING _____	03/15/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANCTUARY AT HOLY CROSS--INDIANA	17475 DUGDALE DR SOUTH BEND, IN46635

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	oriented Resident # E on 3/15/11 at 2:40 P.M., she indicated she often has to wait two or more hours before someone comes to answer her call light. "If a person died in this place, no one would know until morning. What if my roommate had a heart attack? How would I get her help?" She further indicated she had been given a laxative because she was having difficulty with constipation and had soiled herself. "I had Depend's (an incontinence brief) on. I try to keep a Depend's on because you never know when they (staff) are going to show up. (CNA # 2) came in and told me she would clean me up when I finished. I didn't know if I was finished or not. I know it was loaded. She made me wait a long time before she came back to clean me up. The next day my butt was sore and bleeding. I am (age) years old and s--- and p----- my pants two times in one night because no one came." A Social Service MDS (Minimum			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155506	A. BUILDING _____ B. WING _____	03/15/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANCTUARY AT HOLY CROSS--INDIANA	17475 DUGDALE DR SOUTH BEND, IN46635

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Data Set) Assessment Note, dated 3/15/11, indicated, "...Resident (#E) is alert and oriented to time, place, and situation. Resident scored 15 out of 15 indicating normal cognitive functioning on 3/07/11...." 4. During initial tour of the facility on 3/14/11 at 11:50 P.M., Resident #F's family member reported the poor response of facility staff to answering call lights and providing necessary care. She indicated she has found her mother with dried feces on her backside and between her legs. "I frequently find her with an odor and her call light disabled... I'm willing to organize a fund raiser so the facility can afford to hire some part-time help. I hear people calling out 'Help me. Help me'." Resident #F's clinical record was reviewed on 3/15/11 at 4:35 P.M. and indicated diagnoses of, but not limited to: history of CVA (stroke), diabetes, and vascular dementia.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155506	A. BUILDING _____ B. WING _____	03/15/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANCTUARY AT HOLY CROSS--INDIANA	17475 DUGDALE DR SOUTH BEND, IN46635

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Review of Resident #F's MDS (Minimum Data Set) Assessment, dated 1/21/11, indicated, she needed extensive physical assistance of two staff for toilet use (how resident uses the toilet room, commode, bedpan, or urinal; transfers on/off toilet; cleanses self after elimination). It further indicated Resident #F was frequently incontinent of urine and occasionally incontinent of bowel. A Care Plan, updated 1/20/11, indicated, "Problem(s): I require extensive assist with ADL's (activities of daily living) due to weakness, decreased mobility and effects of CVA...Approach(s): ...Encourage me to use call light for assistance. Remind me where it is when you're ready to leave the room...I need assist with proper pericare after each incontininit (sic) episode...." A Social Service Progress Note,			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155506	A. BUILDING _____ B. WING _____	03/15/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANCTUARY AT HOLY CROSS--INDIANA	17475 DUGDALE DR SOUTH BEND, IN46635

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	dated 1/24/11 at 3:42 P.M., indicated, "...Res (resident) is alert and oriented to person with forgetfulness...Severe cognitive impairment...." During an interview with a second family member on 3/15/11 at 4:20 P.M., she indicated it takes a long time for staff to answer call lights. She further indicated she found her mother in BM (bowel movement) three weeks ago. A facility policy titled "Incontinence Management, Urinary," dated 1/08/11, indicated, "...To manage functional (total) incontinence, frequently assess the patient's mental and functional status...respond to his calls promptly...clean the perineal area frequently...control foul odors as well...." A facility policy titled, Incontinence Management, Fecal," dated 1/08/11, indicated, "...In elderly patients,			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155506	A. BUILDING _____ B. WING _____	03/15/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANCTUARY AT HOLY CROSS--INDIANA	17475 DUGDALE DR SOUTH BEND, IN46635

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	fecal incontinence commonly follows any loss or impairment of anal sphincter control...maintain effective hygienic care to increase the patient's comfort and prevent skin breakdown and infection. Clean the perineal area frequently with a skin cleaner, and apply a skin protectant cream after every incontinence episode. Control foul odors as well...." This federal tag relates to Complaints IN00087550. 3.1-38(a)(3)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155506	A. BUILDING _____ B. WING _____	03/15/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANCTUARY AT HOLY CROSS--INDIANA	17475 DUGDALE DR SOUTH BEND, IN46635

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0469 SS=E	Based on observation, interview, and record review, the facility failed to provide adequate pest control as evidenced by live ants and a spider in the East Dining Room. This deficient practice had the potential to affect 58 of 58 residents residing on the East Unit. Findings include: During environmental tour of the East Dining Room on 3/15/11 at 3:25 P.M., 10 to 12 small red ants were observed along the cove base directly under the large East window. A scant amount of brown particles were on the floor by the cluster of ants. A large web was also observed in the corner along the floor base on the East wall and contained a live spider. During an interview with a family member of Resident # E on 3/14/11 at 12:30 P.M., she indicated on 3/11/11 she observed numerous, small black ants in the Resident's	F0469	F 4691. What corrective action will be accomplished for those residents found to be affected by the deficient practice:Pest control was notified on 3/15/11 for follow up service. On 3/16/11 Pest control was here found no ants in East Dining Room. They did apply ant bait to dining room.2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken for any other affected resident.Residents in the East Dining room have the potential to be affected. The facility has a monthly Pest Control provider and they will come as needed when pest are identified in facility.3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.Maintenace Director or designee will do rounds Monday thru Friday to check for insects or pest in facility. All staff will report to Maintenace Director or Administrator if they notice any pest in building. Maintenace will remove pest and pest control company will be notified of issue.4. How the corrective action will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put in place.The Maintenenace Director will report results of rounds to the Mission Driven Quality Improvement	03/29/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155506	A. BUILDING _____ B. WING _____	03/15/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANCTUARY AT HOLY CROSS--INDIANA	17475 DUGDALE DR SOUTH BEND, IN46635

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	bathroom and they were coming out of her floor vent. She stated she used a medicine cup to cover the ants and then brought it to the attention of the Administrator. On 3/15/11 at 2:40 P.M., during an interview with Resident # E, she indicated she found two ants in her room that morning. She wheeled her self out into the hall and asked the Maintenance Supervisor to take care of the ants. During an interview with Employee # 3 on 3/15/11 at 3:10 P.M., he stated, "The only time I see ants is when the resident's eat in their room. I usually see them along the border of the floor in the dining room. I scrape them up and then I spray the floor and it usually lasts for awhile." The Maintenance Supervisor indicated in an interview on 3/15/11 at 5:40 P.M., he went into Resident # E's room, prompted by her		(MDQI) monthly times 3 months. The MDQI committee will review findings to determine if audits can be suspended, if consistent compliance is met for one quarter. Additional Action Plans will be created and implemented as needed based on findings of audits.5. Completion date March 29,2011	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155506	A. BUILDING _____ B. WING _____	03/15/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANCTUARY AT HOLY CROSS--INDIANA	17475 DUGDALE DR SOUTH BEND, IN46635

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	request, but did not see any ants. Review of a Service/Invoice received on 3/15/11 at 4:00 P.M., from the Maintenance Supervisor, indicated that (Name) Pest Control Company serviced the facility last on 3/7/11 at 2:45 P.M., and treated "...all common areas, kitchen & break room plus 4 rms (rooms)....Treated E-31, W-29-31-32 for ants...." This federal tag relates to Complaints IN00087550. 3.1-19(f)(4)			